

## **Policy, Procedure & Guidance on the Mental Capacity Act & the Deprivation of Liberty Safeguards**

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1	21.01.15	<i>New Trust policy to provide guidance and resources for implementation of key legislation: MCA &amp; DoLS</i>
2	28.12.2016	<i>2 year review and update</i>

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## **PART 1 POLICY BACKGROUND**

### **1. Policy Statement**

2gether NHS Foundation Trust is committed to providing safe and effective services that align to the legal requirements of the legislation that governs practice in the field of mental health. Having clear guidance on how to apply the legal frameworks available is essential in safeguarding the human rights of the service users who access Trust services and provide assurance to the regulatory bodies which monitor Trust services.

This policy includes relevant procedures and guidance for practitioners to apply the legal requirements relating to the Mental Capacity Act and DoLS in 2gether Trust services.

### **2. Introduction; MCA & DoLS**

2.1 The Mental Capacity Act (MCA) 2005, launched in 2007 provides a framework to empower and protect some of the most vulnerable people in society. It provides a test for capacity and makes it clear where a person does not have capacity who can take decisions, and sets in statute a Best Interest checklist that needs to be applied in this circumstance.

2.2 Key Messages of the Mental Capacity Act (MCA) 2005:

- applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves
- designed to protect and restore power to those vulnerable people who lack capacity
- supports those who have capacity and choose to plan for their future – this is everyone in the general population who is over the age of 18 (note 16/17 year olds cannot make an Advance Decision or Lasting Power of Attorney)
- provides legal protection in practice for health and social care staff and support and guidance for carers
- provides a Code of Practice with which all professionals have a duty to comply
- provides five statutory principles which are the benchmark of the MCA and must underpin all acts carried out and decisions taken in relation to the Act.

The 5 key principles of the MCA:

- 1) A person must be assumed to have capacity. Where there are concerns capacity needs to be assessed.
- 2) All practical steps need to be taken to help someone make a decision
- 3) An unwise decision does not indicate a lack of capacity
- 4) Any act or decision made where a person does not have capacity must be in the person's Best Interests.
- 5) Any act or Best Interest decision should aim to be the least restrictive option to the person in terms of their rights and freedom of action.

2.3 The deprivation of liberty safeguards were introduced to provide a legal framework around the deprivation of liberty. Specifically, they were introduced to prevent

breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of HL v the United Kingdom (commonly referred to as the 'Bournemouth' judgement). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under common law in his best interests, but this challenged by HL's carers. In its judgment, the ECtHR held that this admission constituted a deprivation of HL's liberty and, further, that:

- the deprivation of liberty had not been in accordance with 'a procedure prescribed by law' and was, therefore, in breach of Article 5(1) of the ECHR, and
- there had been a contravention of Article 5(4) of the ECtHR because HL had no means of applying quickly to a court to see if the deprivation of liberty lawful.

To prevent further similar breaches of the ECHR, the Mental Capacity Act 2005 was amended to provide safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate for the person at that time. These safeguards are referred to as 'deprivation of liberty safeguards'.

- 2.4 The safeguards apply where that person's care is being delivered in a registered care home or hospital and has not been authorised under the Mental Health Act 1983.
- 2.5 The safeguards came into force in April 2009. A Managing Authority (together Trust as a provider is a 'Managing Authority') must seek authorisation from a Supervisory Body (In Gloucestershire this is Gloucestershire County Council and in Herefordshire this is Herefordshire County Council) in order to lawfully deprive a person of their liberty. Where a request for a standard authorisation for deprivation of liberty is made, the Supervisory Body is responsible for conducting a number of assessments to determine whether the authorisation is to be granted. Where the outcome of any of the 6 assessments is negative, the authorisation cannot be granted. Help and guidance can be sought from the DoLS Local Authority teams in each county.

See [Appendix 5](#).

- 2.6 All organisations are required to have MCA and DoLS policies for staff to be supported in applying the legislation in practice. CQC outline the standards for implementation of both the MCA and DoLS requirements.

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards; Guidance for providers which can be downloaded from:

<http://www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-about-compliance/how-mental-capacity-act-2005>

### 3. Purpose

This policy has been written to provide a clear framework for application of the Mental Capacity Act and Deprivation of Liberty Safeguards within the Trust. It outlines how the principles of the Acts are applied within the Trust, and the Trust process and guidelines to support consideration of and where required the application for a Deprivation of Liberty authorisation.

### 4. Scope

4.1 This policy includes specific procedures and guidance relating to the MCA & DoLS to apply to all areas of clinical practice within the Trust. This includes:

- Procedure for assessment and recording capacity relating to day to day decisions and significant decisions.
- Procedure for recording Best Interest decisions
- Procedure for considering DoLS applications
- Process for applying for a DoLS authorisation

4.2 This policy does not cover wider application of the MCA and DoLS, details of which are available in the relevant Codes of Practice and the Gloucestershire Mental Capacity Act Multi-Agency Policy, Procedures and Guidance (May 2014), Gloucestershire DoLS policy and Herefordshire MCA & DoLS Policies.

The Trust is signed up to the Gloucestershire Mental Capacity Act Multi-Agency Policy, Procedures and Guidance (May 2014). The policy and associated appendices can be accessed through;

Link: [www.gloucestershire.gov.uk/extra/mcapolicy](http://www.gloucestershire.gov.uk/extra/mcapolicy)

4.3 This policy should be read alongside the Trust's policies and procedures on:-  
*Consent to Examination or Treatment Policy 2015*  
*Do Not Attempt Resuscitation (DNAR) 'Not for CPR' Policy 2014*  
*Assessment and Care Management Policy 2014*  
*Advance Statements and Decisions Procedural Guidance 2014*  
*Positive and Proactive Care: reducing the need for restrictive interventions' (April 2014)*

### 5. Context

This policy has been written to ensure that the Trust can demonstrate a robust and effective process relating to assessing and recording capacity, making and recording Best Interest decisions and considering when and how to apply for a deprivation of liberty authorisation. A number of key publications have been drawn on to help develop this document which has emerged from wider Government scrutiny of the application of the legislation:

- *The House of Lords Select Committee review of the MCA and DoLS (2014)*
- *Mental Capacity Act 2005 – Valuing every voice, respecting every right: One Year On DoH 2015*
- *The Supreme Court ruling on Cheshire West (19.03.2014)*
- *CQC guidance document 14<sup>th</sup> April 2014*
- *SCIE Report 70: The Mental Capacity Act and care planning (2014)*
- *The Law Commission's Interim statement for DoLS 2016*

The key issues raised as a result of the Governments scrutiny on the MCA & DoLS processes have been to highlight that although the MCA 'continues to be held in high regard', it has not met the 'high expectations it raised', due to a lack of understanding and awareness, a persistent culture of paternalism in health service and aversion to risk in social care. The need to move towards choice and self-determination has been further developed in the Care Act 2014.

## 6. Duties

- 6.1 The person responsible for application of the legal frameworks at a board level is the Director of Quality. The day-to-day responsibility is held by the MCA/DoLS Organisational Lead for the Trust who is responsible for developing and maintaining the policy, offering advice and guidance to staff, ensuring that training is developed and delivered, and monitoring compliance across the Trust against this policy.
- 6.2 The Mental Health Legislation Scrutiny Committee is responsible for the governance relating to this policy. They receive copies of any reports and audits relating to standards and practises in this policy, as a minimum this must include an annual report.
- 6.3 All staff who have contact with service users are responsible for using the policy correctly to ensure patient's legal rights are upheld.

## 7. Definitions

MCA: Mental Capacity Act

MHA: Mental Health Act

- **DoLS: Deprivation of Liberty Safeguards** - Deprivation of Liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Case law continues to define its meaning in practice. There is no simple definition of deprivation of liberty.
- **Managing Authority** - The person or body with management responsibility for the hospital or care home in which a person is, or may become deprived of their liberty
- **Restraint** - The use, or threat, of force to help do an act, which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
- **Standard Authorisation** - This is the formal agreement to deprive a relevant person of their liberty in the relevant hospital or care home, given by the Supervisory Body, after completion of the statutory assessment process.
- **MCAGG** - Mental Capacity Act Governance Group (Gloucestershire)
- **HSAB** - Herefordshire Safeguarding Adults Board

## 8. Ownership & Consultation

The owner of this document is the Director of Quality and the 2<sup>gether</sup> Trust MCA& DoLS Organisational Lead.

It has been produced with the active consultation of the Mental Health Legislation Scrutiny Committee, the MCAGG, and the Herefordshire Safeguarding Adults Board MCA & DoLS sub group.

### 8.1 MCA Organisational Lead

This is the named individual responsible for promoting the quality and efficacy of the

services provided to adults who may lack capacity within their organisation. The person provides a contact point for other agencies and is responsible for linking into the wider Gloucestershire MCAGG and the Herefordshire Safeguarding Adults Board MCA & DoLS sub group to share information and provide specialist advice.

## **9. Ratification Details**

This document has been ratified by the Mental Health Legislation Scrutiny Committee/ Trust Board Development Committee before implementation.

## **10. Release Details**

- This document is a freely available public document without any restrictions of confidentiality
- It is located on the Trust's intranet site under Essentials - Policies – MCA & DoLS

## **11. Review Arrangements**

- This document will be reviewed no later than every 3 years
- Changes to the legislation relating to MCA and DoLS may require the document to be reviewed.
- Case law and the review of the DoLS legislation by the Law Commission may require the document to be reviewed earlier

## **12. Process for Monitoring Compliance**

12.1 A programme for regular auditing and monitoring is currently carried out as agreed by the Mental Health Act Scrutiny Committee. This includes the following;

- a. audit against the recording of capacity assessment relating to S58 & S63 of the MHA*
- b. audit exploring recording of capacity within core cluster care planning*
- c. audit of recording capacity relating to consent to admission to 2gether Trust mental health hospitals*

12.2 The Mental Health Act Scrutiny Committee receives copies of any reports, audits and action plans relating to standards and practises in this policy.

## **13. Training**

13.1 Awareness training for MCA & DoLS is set out in a bespoke E.Learning training package which is mandatory for all clinical staff working in the Trust. An overview of the MCA is also incorporated within the Trust safeguarding 'Think Family' day. Training in this subject area is mandatory for all clinical staff every 3 years. The staff groups to which the training is applicable have been listed in the Trust's annual training plan document which is managed and published by the Trust's Training Department.

13.2 An MCA Peer Supervision & Education Group runs bi-monthly for Trust staff to access updates and opportunities to discuss MCA & DoLS issues relating to practice

## Part 2 ASSESSING CAPACITY & DOCUMENTING CAPACITY ASSESSMENTS

### 14. Over-Arching Principles

#### 14.1 When to assess for capacity;

The MCA Code of Practice identifies a number of circumstances whereby it would be necessary to question a person's capacity to make a specific decision (4.35)

- the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision
- somebody else says they are concerned about the person's capacity, or
- the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works

#### 14.2 Capacity and Care Planning:

The MCA Code of Practice states that capacity needs to be considered as an integral part of care planning:

(CoP: 4.29) Capacity should always be reviewed:

- whenever a care plan is being developed or reviewed
- at other relevant stages of the care planning process, and
- as particular decisions need to be made.

#### 14.3 In <sup>2</sup>gether Trust there are a number of occasions where it is necessary to consider capacity:

*Day to day decisions:*

- Where care plans are proposed and reviewed
- Where care planning involves restrictive interventions

*Significant decisions:*

- When it is proposed that a person is admitted to one of the trust mental health hospitals
- At the start of mental health treatment for a person detained using the MHA (Sec 58 /63) and at the 3 month stage of treatment
- Where it is proposed that a person has a specific investigation/treatment for their physical health, for example an amputation, heart surgery, blood test, tooth extraction, serious surgical treatment such as back surgery.
- Where there are complex issues relating to consent to sharing information

#### 14.4 The core principles relating to assessing capacity are set out in section.1(1). s.1(2): a person must be assumed to have capacity unless it is established that he /she lacks capacity; s.1(3): a person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

#### 14.5 The presumption that a person has capacity is fundamental to the Act. The burden of proving a lack of capacity to take a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf. The standard of proof which must be achieved is on the balance of probabilities. This means that the assessor must consider 'is it more likely than not' that the person has



the cognitive ability required to understand and think through the information relevant to the decision in hand.

#### **14.6 Defining a lack of capacity**

A person who lacks capacity is defined under s.2(1) MCA 2005 thus:

*'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.'*

There are 2 stages to the capacity assessment namely:

- a) whether the person is 'unable to make a decision for himself' (often referred to as the 'functional test'); and
- b) whether that inability is because of 'an impairment of, or a disturbance of the functioning of, the mind or the brain' (often referred to as the 'diagnostic test').

#### **14.7 The Diagnostic Test**

The impairment or disturbance in the functioning of the mind or brain can be temporary or permanent: if temporary, there needs to be consideration why it is that the decision cannot wait until the circumstances have changed before the decision is taken.

It is not necessary for the person to have a specific diagnosis but there needs to be 'proof' that something is affecting the person's thinking; this might be due to cognition being impaired because of a dementia, psychosis or depression as well as physical conditions causing confusion, drowsiness, concussion, or the symptoms of drug or alcohol abuse.

NB: It is not necessary for the impairment or disturbance to fit into one of the diagnoses in the ICD or DSM

#### **14.8 The Functional Test**

The elements of the functional test state that the person is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision; or
- to retain that information; or
- to use or weigh that information as part of the process of making the decision; or
- to communicate his decision (whether by talking, using sign language or any other means).

NB: MCA Code of Practice (4.15) states:

The first three (URW) should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

**15. Procedure for assessing capacity (see also Appendix 1)**

a) Identify the area of decision making there are concerns about:

For example there may be concerns about a person's ability to consent to .....  
*their care plan / their mental health treatment / their physical health care or treatment / admission to hospital / sharing their medical information / where to be accommodated*

**15.1 Example A: can the person consent to a mental health hospital admission?**

b) Identify what the person needs to know in order to be able to make this decision. There may be a need to find out more information about the person's situation in order to identify what the person needs to know. (the MCA refers to this as the potential consequences of deciding one way or another)

*Example A: can the person consent to mental health hospital admission?*

What might the person need to know? : the person may need to know where the hospital is, what might happen when they are admitted, what might happen should they not be admitted. How being admitted or not may impact on their personal situation and well-being.

c) Identify who may be best to have the conversation with the person in order to make a judgement as to whether the person can understand and think through the information that is needed to make the decision. The Act refers to this as the 2 stage test; (see 14.3 above). The test is to check whether the person can demonstrate that it is more likely than not that they can understand and think through the pros and cons of the relevant information.

d) Whoever is undertaking the assessment needs to provide the information to the person about the concerns raised by others and what is being proposed using appropriate language or other communication methods suitable to the person, and then check the person's ability to understand and think through the information by asking open questions.

Examples of relevant information to give when undertaking the assessment. Consider what the person needs to know about what is being proposed:

Give relevant information about the concerns:

*'There are concerns about .....you are not keeping well and /have not been eating enough/sleeping enough/out and about as you would normally be/taking the tablets that keep you well/your husband is struggling to keep both of you well/ your mood/ how distressed you have been.*

Give information about the options;

*The plan is .....to consider you spending some time in hospital at Wotton lawn hospital/ Charlton Lane Hospital for about 4 – 6 weeks / the doctors will check out your tablets / support you to get a programme in place to help with how you are feeling.*

Once the information has been given to the person, ask open questions to check the person's understanding and ability to think through the information:

*Can you tell me what this means to you?*

*What you think about this?*

*Can you say what it might mean to go to hospital? what might it mean to stay at home?*

In summary this is a 3 stage process:

- Check what information the person needs to make the decision
- Give the information to the person in the best way possible for them
- Check to see if they can understand the information and think it through by asking open questions (rather than questions that need a 'yes' or 'no' answer).

## **15.2 Example B: Can the person consent to PEG feeding?**

For people who have significant compromised cognition:

Example:

It might be helpful to think through who is best to have this communication with the person and where possible use someone who has a trusted relationship with the person, and who understands their communication style.

*Give relevant information about the concerns:*

This information would need to be given in an accessible form including objects of reference where possible. Introduce the topic: This may be in the form of symbols/photos/drawings with simple basic language. This may be accompanied by signing or assistive communication devices.

For example: use smiley/sad/don't know face on a talking mat then offer a picture/draw a picture of the food/of being assisted/discomfort when swallowing/etc.

Give information about the options;

'PEG feeding is an operation/you need to come into hospital/there are risks of infection/it may not improve your chest.

Once the information has been given to the person, depending on how the person communicates, look to use non-verbal communication / symbols (total communication) for a response regarding the options.

Describe the person's response or take a photograph of symbols/cards to demonstrate your judgement on their ability to think through, weigh up and communicate their decision.

In summary this is a 3 stage process:

- Check what information the person needs to make the decision
- Give the information to the person in the best way possible for them
- Check to see if the person can understand the information and think it through

## **16. Documenting Capacity Assessments**

### **16.1 Procedure for documenting capacity assessments related to day to day decisions**

Day to day decisions relating to the provision of care such as personal hygiene /

social care /nutrition and safety issues such as hoisting/splints/lap belts must be captured within core cluster care plans or add into bespoke care plans. A capacity assessment is incorporated within each of the cluster care plans to be completed relating to the person's capacity to consent to the care plan. **Refer to relevant step by step guidance on Trust website**

16.2. *Procedure for documenting capacity assessments related to significant decisions*  
 Significant, more complex decisions that are usually one off decisions, such as being admitted to hospital, accommodation moves or significant treatments such as PEG feeding, significant change of mental health medication **must be documented in the patient's health and social care record following the relevant step by step guidance on Trust website**

16.3 *When documenting the outcome of the assessment consider the following:*

- Was the person able to demonstrate an ability to connect to the reality of their current situation?
- Could the person grasp the essential meaning of what was being described?
- What did the person say which evidenced to you that the person was able / not able to make sense of what was being proposed? Give short quotes outlining what the person said to demonstrate evidence of your judgement.
- Be aware that the fact that a person agrees with you or assents to what is proposed does not necessarily mean that they have capacity to make the decision.
- Avoid questions that need only a 'yes' or 'no' answer (for example, did you understand what I just said?).

**Examples of documenting:**

**Example 1: Documenting day to day capacity decisions in care planning:**

<b>Goal</b>	<b>Activities</b>	<b>Clients View</b>
Mental Capacity Assessment	<p>You have capacity to consent to this plan and will receive a copy of the care plan.</p> <p>OR</p> <p>At present you do not have capacity to consent to this care plan. You are unable to fully understand, retain or weigh up the relevant information about you care/treatment outlined in this plan. However your views and those of significant others have informed this care plan that has been written in your best interests</p>	<p>(Example : Has capacity)</p> <p>I spoke to X about this care plan.X said '.....;.            This demonstrated X could make sense of and connect to the information within the care/treatment plan and think it through</p> <p>(Example : lacking capacity)</p> <p>I spoke to X about this care plan.X said '.....;.            This demonstrated X could not make sense of and connect to the information within the plan and the care being proposed and/or think it through</p>

**Example 2: Documenting a person's capacity to consent to hospital admission.**  
**Document in the patient's health and social care record following the relevant step by step guidance.**

I spoke to the person about their low mood and about the proposal of coming to hospital for treatment. The person said very little in response though at times affirmed what I was saying through nods and saying 'that's right' to the information. When weighing and considering the information however the person could not demonstrate an ability to think through what was proposed and kept repeating "it's all going to end, its ending now' I can see it ending'.

Diagnostic test YES low mood

Functional test

Understand: Yes

Retains: Yes

Weigh up: Unable to demonstrate this

Communicate: N/A ( ref: MCA Code of Practice (4.15))

*NB: Completion of this capacity assessment should be completed by the team arranging admission, for example a member of the Crisis and Home Treatment Team, and where it has not been completed at the time of admission, to be completed by the admitting clinicians (doctor/nurse) as part of the admission process.*

*Where it has been completed by the Crisis and Home Treatment Team it should be reviewed by admitting clinicians (doctor and/or nurse) and a narrative entry made in the notes. If there is any change to consent/capacity this should be updated and a new capacity assessment completed.*

**Example 3: Documenting capacity to consent to move to care home accommodation**  
**Document in the patient's health and social care record following the relevant step by step guidance.**

'I spoke to the person about the concerns about their well-being (due to evidenced self-neglect issues). The person was disorientated to time, thinking that their children were upstairs at times during the conversation and responded by saying 'I can't see what all the bother is about'. 'you are the bother bother' and 'I can manage this house, my children, my children are here'.

The person could not connect to what was said to understand the reality of their current home situation.

Diagnostic test YES cognitive impairment

Functional test

Understand: Unable to demonstrate this

Retains: No (see above)

Weigh up: No (see above)

Communicate: N/A( ref: MCA Code of Practice (4.15))

## 17. Capacity to Consent to mental health treatment in hospital

Assessment of a person's capacity to consent to mental health treatment in hospital and consideration of their legal status must be documented in the patient's record following the relevant guidance. **(See Appendix 2)**

*Completion of the capacity assessment should be completed by the team arranging admission, for example a member of the Crisis and Home Treatment Team or the doctors who have undertaken a Mental Health Act assessment. It should be done using the MCA form and use of this referenced by a narrative entry in the Rio progress notes. Capacity should be reviewed by the admitting clinicians (doctor/nurse), at weekly MDT, by the RC before the patient becomes subject to s58 and whenever clinical presentation indicates that consent/ capacity to consent to mental health treatment in hospital has changed (e.g. if a patient is refusing treatment or asking to leave hospital)*

## 18 Covert medication (Ref: POPAM Guidance 16)

### 18.1 Introduction

This guidance relates to the covert administration of medicines to individuals who do not have capacity to give informed consent to treatment and are resistive to taking tablets /capsules or liquid preparations when they are offered openly.

#### **The NMC position statement on covert administration of medicines 2001 states that:**

*“Disguising medication in the absence of informed consent may be regarded as deception. However a clear distinction should always be made between those patients or clients who have capacity to refuse medication and whose refusal should be respected and those who lack capacity. Among those who lack capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise.”*

#### **The Royal College of Psychiatrists has also issued a statement on the covert administration of medicine which states:**

- The importance of respecting the autonomy of individuals who refuse treatment
- That there may be times when severely incapacitated individuals can neither consent nor refuse treatment
- Treatment should be made available to severely incapacitated individuals judged according to their best interests and administered in the least restrictive manner
- In exceptional circumstances it may be necessary to administer medication in foodstuffs without the individuals awareness that it is being done

### 18.2 Professional conduct

Registered nurse involved in covert administration of medicines should be fully aware of the aims, intent and implications of such treatment.

Registered practitioners should reflect on treatment aims of disguising medication. The treatment must be necessary to in order to save life, prevent deterioration or ensure improvement in the individuals' physical and/or mental health.

They should not act unilaterally and in isolation. Practitioners are personally accountable for their practice.

### **18.3 Capacity and Consent Issues:**

Capacity to consent to treatment must be assessed. This must be recorded in the Capacity Assessment Form within the MCA and BI folder on Rio.

When individuals have capacity to give or withhold consent to treatment they must be given information about the nature, purpose, associated risks and the alternatives to the proposed medication. A competent adult has the right to refuse treatment, even if refusal will adversely affect his or her health or shorten his or her life, unless the patient is subject to the Mental Health Act and the section they are subject to includes Part 4 where treatment can be forced. Otherwise registered nurses must, therefore, respect a competent adult's refusal in the same way as their consent.

NB: If the treatment is for physical health then this will not be covered by Part 4 of the MHA (unless the physical health condition is directly associated with the mental health condition such as anorexia)

Where a person is subject to the MHA there will therefore be occasions where both the MHA and the MCA will be applicable. The MHA will govern treatment decisions relating to mental health (and although capacity must be assessed, a person can be given treatment even if they have capacity and refuse). The MCA will govern treatment decisions relating to physical health; capacity must be assessed and if the person does not have capacity then the treatment can be given as a best interest decision (where it is judged to be in the patient's best interests)

### **18.4 Best Interest Decisions to administer medication covertly**

When a person is assessed as not having capacity to consent or not to their medical treatment then a Best Interest decision(s) will need to be made. Where a **Best Interest Decision** to administer a medication covertly is made this should not be considered routine. Any decision to do so must be reached after assessing the care and treatment of the patient or client individually and considering less restrictive options regarding the administration of the medication. (ie: can it be given in a form that would be accepted by the person such as liquids). It must be patient specific in order to avoid the ritualised administration of medication in this way.

### **18.5 Advance Decisions**

The person may have indicated refusal to the treatment at some stage whilst still competent, in the form of an Advance Decision. Where these are known the MDT team should note them, and unless the relevant treatment can be provided under Part 4 of the MHA, the Advance Decision must be respected, providing that the decision in their Advance Decision is clearly applicable to the present circumstances and there is no reason to believe the person has changed their mind. (see Trust ACP policy )

### **18.6 Statement of Wishes and Preferences**

The person may have or statement of wishes and preferences at some stage whilst still competent. If any of these relate to the treatment being given they must be considered. The person's viewpoint, past and present, is widely regarded in law as having 'magnetic importance' in the context of Best Interest decision making.

### **18.7 Responsibility for Best Interest Decisions for Covert Medication**

The Best Interest decision to give covert medication should be a multi-disciplinary decision and be planned and documented within care planning. Those involved in the decision must be:

- Prescriber (usually this will be Doctor with medical responsibility though this may be a nurse/pharmacist prescriber in some instances)
- Named Nurse (or equivalent member of the nursing team who will be representing those nurses administering the medication)
- Any allied professional involved in the individuals' care (SALT may be particularly appropriate)
- Pharmacist (The method of administration of the medicines must be agreed with the pharmacist)
- Relatives / informal carers (relatives should always be consulted unless there is rationale why this would not be appropriate)

The decision and the action to be taken, including the names of all parties concerned, should be documented in a **Covert Medication Care Plan** and reviewed at appropriate and defined intervals.

No one, not even a spouse, can consent for someone else, although relatives and close friends have a legal right to be consulted as part of the best interest decision process. If a relative or close friend is the welfare Lasting Power of Attorney for the person, then there is a requirement to check whether they have decision making authority with respect to the treatment being proposed. (see MCA policy)

### 18.7 Emergency Situations

In an emergency situation the prescriber and the nurse administering the medication could make a decision to covertly medicate.

This must be a joint decision. There should be broad and open discussion among the multi-professional clinical team and the supporters of the patient, and agreement that this approach is required in the circumstances. Those involved should include medics, registered nurses, carers, relatives, and members of the multi-disciplinary team (especially the pharmacist).

Regular attempts should be made to encourage the patient or client to take their medication. This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual using a range of communication methods.

### 18.8 Process for Covert Medication

1. Assess Capacity to consent to treatment and record in Rio (see above).
2. In consultation agree Best Interest Plan for covert medication (see above).
3. Identify medication to be administered covertly.
4. Determine which food could be considered to be the medium for covert administration.
5. Contact Pharmacist with above information.
6. Pharmacist provides written information on how to administer the specific medication safely.
7. The details from Pharmacist are to be inserted within the Covert Medication Care Plan. (see pharmacist's involvement below)
8. A copy of the instructions from Pharmacist to be attached to patient prescription chart.



### 18.9 Pharmacist's Involvement

- The pharmacist's opinion should be sought on the most appropriate form of medication administration e.g. syrups. The pharmacist should always be involved in the decision regarding covert administration of medication and the method of administration must be agreed with the pharmacist and recorded in the care plan at the earliest opportunity.
- A medicine with a product license would be used in an unlicensed manner if the dose, route or form were outside the licensed terms. A nurse who administers a medicine by crushing a tablet or opening a capsule would be using the medicine in an unlicensed form.
- The prescriber should always be aware of each medicine a patient has administered covertly, as this will be an unlicensed use of the medicine.
- Nurses who administer medicines in an unlicensed form independently would be personally liable and be required to justify their actions in the event of any adverse reaction.
- It is important to ensure that giving medication in food does not compromise the individual's nutrition or affect the properties of the medication; again the pharmacist will advise as to disguising medication in food.
- When necessary to disguise medicines they should be mixed in a small portion of food or liquid rather than a full meal or drink. Advice must be obtained from the pharmacist as to what food or drink is suitable.
- The food the medicine is to be disguised in has to be documented clearly in the care plan.

### 18.10 Lack of awareness

Administration of medicines to individuals who lack the capacity to consent and are unable to appreciate they are taking medication, for example, unconscious individuals or individuals with limited cognitive ability, should not need their medication to be administered covertly. If these individuals recover awareness, their consent should be sought at the earliest opportunity. These individuals, albeit assessed as lacking capacity, may not require this to be administered covertly. (*those for whom no disguising is necessary because they are unaware they are receiving medication*) as identified by NMC)

## **PART 3 BEST INTEREST DECISION MAKING**

### **19. Working out who is the Decision Maker**

The decision-maker is the person who is deciding whether to take action in connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf. This may mean that the decision-maker is not the person who knows the person best.

Where a person has made a Lasting Power of Attorney, the Decision Maker is the person's attorney for the decisions for which they have attorney powers. For example a welfare attorney may have decision making authority for health and social decisions and a finance attorney for all decisions relating to a person's finances.

Further advice relating to attorneys can be found on: *Link:* <https://www.gov.uk/>

The MCA does not specify professional roles or require certain qualifications to be held by the decision-maker.

There are times when a number of people may be involved in making recommendations in relation to a decision. Whilst a collaborative and consensual approach is to be encouraged it is ultimately the decision-maker's responsibility to work out what would be in the 'Best Interests' of the person who lacks capacity.

Determining who the decision-maker is depends on the decision and not on the circumstances of the individual:

- Where the decision involves medical treatment, the doctor proposing the treatment is the decision-maker
- Where nursing care is provided, the nurse (either the care co-ordinator in the community or the named nurse in inpatients) proposing the care plan is the decision-maker

### **20. Best Interest Checklist**

The Best Interest Checklist provides the framework for the areas of consideration that need to take place where a person lacks capacity relating to an area of decision making:

20.1 Find out the person's views; the person's viewpoint should be considered as a specific part of the best interest process.

- try to find out the views of the person who lacks capacity, including:
- the person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
- any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
- any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

## 20.2 *Consult others*

- if it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:
- anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
- anyone engaged in caring for the person
- close relatives, friends or others who take an interest in the person's welfare
- any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
- any deputy appointed by the Court of Protection to make decisions for the person

NB: For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted. (see Trust Consent to Examination or Treatment Policy)

## 20.3 *Avoid discrimination*

- do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.

## 20.4 *Assess whether the person might regain capacity*

- consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

## 20.5 *If the decision concerns life-sustaining treatment*

- It should not be motivated in any way by a desire to bring about the person's death.
- There should not be assumptions made about the person's quality of life.
- All reasonable steps which are in the person's best interests should be taken to prolong their life.

There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death.

The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion.

Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.

## 20.6 *When and how to have a best interest meeting*

For chairing a Best Interest meeting an example agenda is available  
(**See Appendix 4**)

## 20.7 *Balance Sheet Approach:*

It is helpful to consider the potential outcomes for a person with regard to the emotional, social and physical needs and weigh up the pros and cons for each of these as a risk/benefit analysis when considering the best interest decision.

## 21. **Recording Best Interest Decisions**

For day to day decisions relating to on-going care and treatment, where there is a capacity assessment within the care plan which identifies that the person lacks capacity to consent to the care plan, the detail within the care plan outlines the best interest decisions relating to the care/treatment.

If there are certain elements of the care plan that the person has capacity to consent to and others where the person lacks capacity this should be reflected within the plan.

For significant decisions, document in the patient's health and social care record following the relevant step by step guidance. This may be supported by other documentation such as minutes/reports from a Best Interest meeting.

## 22. **Restriction and Restraint:**

*Restraint is described within Section 5/6 of the MCA as:*

'any use, or threat of force, to implement a restrictive intervention which the person is resisting, or which restricts the person's liberty of movement, whether or not the person resists, must be a proportionate response to:

- the likelihood of the person suffering harm, and
- the seriousness of that harm.

Sections 5 and 6 of the MCA permit restrictions on liberty in these circumstances, but do not authorise acts that deprive a person of their liberty.

Where restrictions fall short of a deprivation of liberty there needs to be clear care planning to record and identify the rationale and reasoning for the restrictions which are judged to be necessary and proportionate to harm.

Care planning needs to identify what type of restrictions are taking place and what strategies have been considered to minimise the restrictions where possible. Any service user with a behaviour support care plan which includes the use of restrictive interventions should have clear proactive strategies including details of primary and secondary preventative strategies. An example behaviour support care plan is available for guidance.

([See Appendix 3](#))

### 22.2 Different types of restrictive interventions

The Department of Health guidance document 'Positive and Proactive Care: reducing the need for restrictive interventions' (April 2014) provides the following definitions

relating to the different types of restrictions with associated guidance.

22.2.1 Chemical restraint refers to: 'The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness'.

22.2.2 Mechanical restraint refers to: 'the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'.

22.2.3 Physical restraint refers to: 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.

Incidents of physical interventions must be recorded on Trust physical interventions forms and in the progress notes. These forms are sent to the trust PMVA/PBM trainers who monitor the use of physical restraint

Methods of physical restraint are taught to relevant staff by in-house instructors. The training provided includes aspects of theory and practice as outlined in the NICE Guideline 25 for management of acute disturbed behaviour/violence and is consistent with the learning outcomes defined by NHS Security management Service.

**See Trust PMVA & MERT policies.**

Any physical restraint used should:

- be reasonable, justifiable and proportionate to the risk posed by the patient;
- be used for only as long as is absolutely necessary; (MHA C of P, 15.22)

22.2.4 Seclusion refers to: *'The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.'* *'Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.'*

## **PART 4: DEPRIVATION OF LIBERTY SAFEGUARDS**

### **23. Background Information; Deprivation of Liberty:**

23.1 Deprivation of liberty is a concept described in Chapter 2 of the DoLS Code of Practice (2009) and continues to be informed by the Law Commission's review and consultation (2015/2016) .

The Supreme Court in 2014 identified that a person is deprived of their liberty if:

The person is

- under continuous supervision and control and
- is not free to leave,
- and the person lacks capacity to consent to these arrangements.

If a deprivation of liberty is necessary, it can only be authorised by a procedure set out in law, which enables the lawfulness of that deprivation of liberty to be reviewed.

Legal authority to deprive the person of their liberty may be obtained under the Deprivation of Liberty Safeguards (DoLS) in the MCA or by use of the MHA.

Each regime provides a procedure to authorise deprivation of liberty.

The DoLS were incorporated into the MCA to ensure that there is a procedure for authorising deprivation of liberty in hospitals and care homes for adults who lack capacity to consent to admission for the purpose of receiving care and/or treatment. The Court of Protection can authorise deprivation of liberty in other settings such as supportive living or in a person's own home.

23.2 Whether or not the care regime amounts to a deprivation, rather than a restriction of liberty depends on the circumstances of the individual case. There are many factors relating to the restrictions being applied which need to be considered when deciding if the regime amounts to a deprivation of liberty, hence the importance of care planning any restrictive interventions and evidencing how there has been the consideration of minimising these restrictions wherever possible.

### **24. The interface between the MHA and DoLS.**

**Chapter 13 of the MHA Code of Practice (2015) identifies the interface between the MHA and use of the deprivation of liberty safeguards.**

*MHA Code of Practice 13.49*

*If an individual:*

- a. is suffering from a mental disorder (within the meaning of the Mental Health Act)
- b. needs to be assessed and/or treated in a hospital setting for that disorder or for physical conditions related to that disorder (and meets the criteria for an application for admission under sections 2 or 3 of the Mental Health Act)
- c. has a care treatment package that may or will amount to a deprivation of liberty
- d. lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and
- e. does not object to being admitted to hospital, or to some or all the treatment

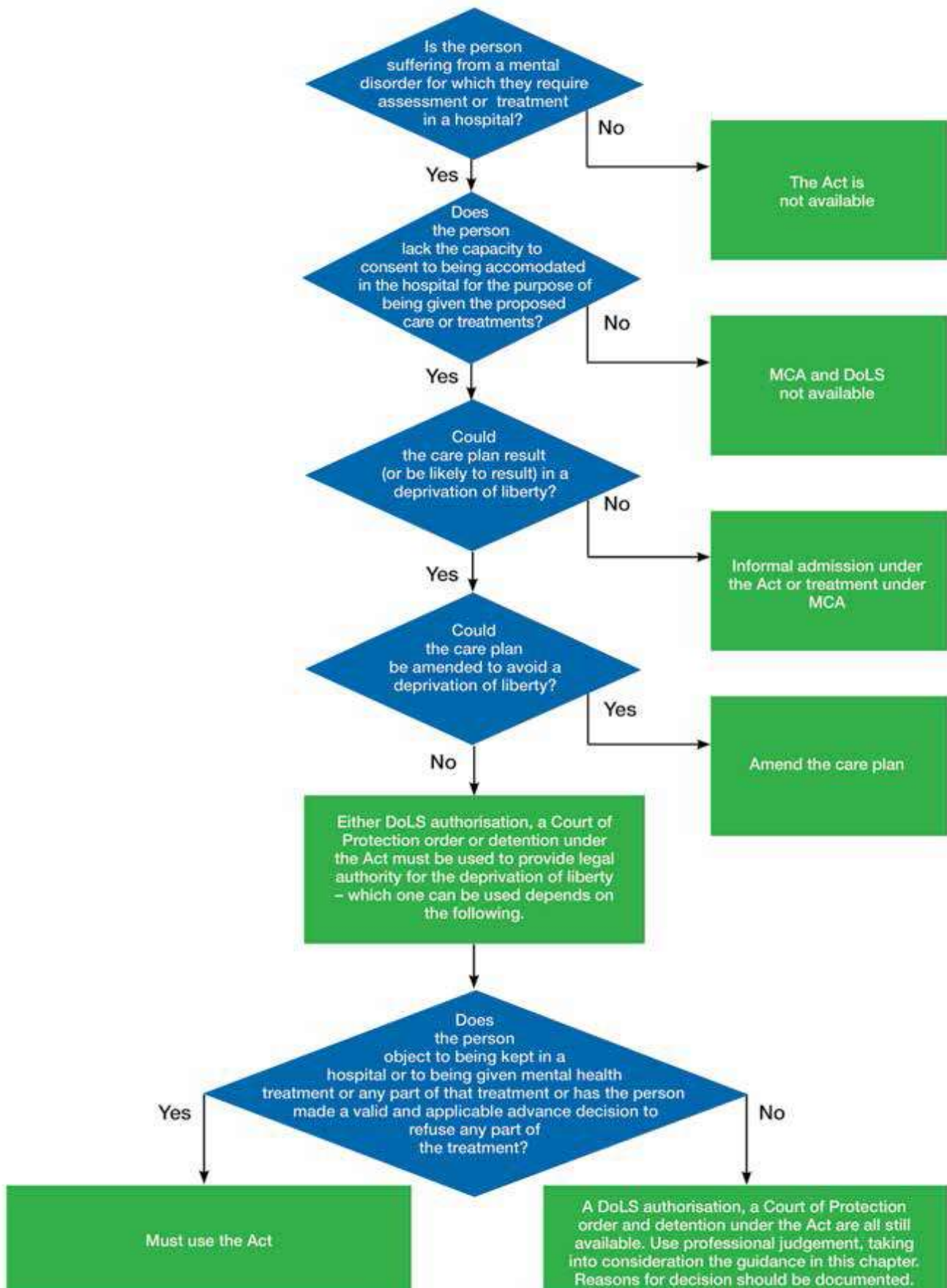
they will receive there for mental disorder.

Then in principle a DoLS authorisation (or potentially a Court of Protection order) and detention under the Act would both be available (subject to the assessments required for a DoLS authorisation, including the eligibility assessment). This is the one situation where the option of using either the Act or DoLS exists. It is important to note that a person cannot be detained under the Act at the same time as being subject to a DoLS authorisation or a Court of Protection order.

- 24.1 It may be necessary to consider a DoLS application in a Trust hospital setting therefore in circumstances where a patient is no longer receiving active assessment and/or treatment for their mental health to which they are considered to be objecting, and need to have restrictions applied which are considered to meet the DoLS threshold while they remain in hospital for a period prior to waiting for an appropriate placement to enable discharge.
- 24.2 The following flowchart is taken from the MHA Code of Practice (16.62, Figure 6) and describes the key decision-making steps when determining whether the Mental Health Act and/or the MCA including the DoLS will be available to be used.

Note: A key area of note is at the time of admission, where if a person lacks capacity to consent to being in hospital for the purpose of being given the proposed care and treatment, consideration must be given as to whether the care plan once the person is admitted will result in a deprivation of liberty. If there is not enough evidence that this will result in a deprivation of liberty then the care plan should reflect the restrictions being applied in the person's best interests under the wider provisions of the Mental Capacity Act and reviewed to continue to consider this throughout the admission.

If there is evidence that this will or is likely to result in a deprivation of liberty, then before considering which legal regime to apply for consideration must be given as to whether the care plan can be amended to be less restrictive.





The flowchart does not replace careful consideration by decision-makers of all relevant circumstances in individual cases. Decision-makers should use their professional judgment within the framework of the legislation

The following grid provides further guidance (Ref: Figure 5, MHA Code of Practice)

	Individual objects to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	Individual does not object to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. Informal admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. DoLS authorisation is available, or potentially a Court of Protection order

## 25. Threshold for DoLS applications

### 25.1 CQC

*CQC Briefing: Deprivation of liberty in health and social care 16/04/14*

The CQC briefing of April 2014 advised providers that in a psychiatric inpatient setting, clinical staff may want to review the situation of all informal patients who lack mental capacity to consent to admission, and consider if they are deprived of their liberty. If they are at risk of being deprived of their liberty, the first step is to scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then the provider must decide between using the Mental Health Act and the MCA deprivation of liberty safeguards to protect the person's rights.

Once there is an outcome of a DoLS application whether this is the outcome of a standard application, or the person is discharged from hospital, or the person is made subject to the MHA or the person dies, the CQC must be notified using the prescribed form.

**25.2** The DoLS procedures were reviewed by the Law Commission in 2015. The Law Commission's consultation on DoLS terminated on the 2nd November 2015. The Department of Health (DoH) responded to the proposals by the Law Commission in December 2015. The Law Commission produced an interim guidance document in May 2016.

The interim guidance identifies that the new scheme being proposed to replace DoLS will not be available for use in mental health hospitals. Also that there will not be any additions into the MHA and that the existing powers of the MHA should be used for compliant incapacitated patients.

**26. Process for making a DoLS application (see [Appendix 5 & 6](#))**

**25. References**

*Mental Capacity Act 2005 London: HMSO*

*DoH (2015) Code of Practice, Mental Health Act 1983 London: TSO*

*Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice: London: TSO*

*DoH; Positive and Proactive Care: reducing the need for restrictive interventions April 2014 Social Care, Local Government and Care Partnership Directorate*

*Skills for Care/Skills for Health (2014) A Positive and Proactive Workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*

*Department of health letter to MCA-DoLS leads in local authorities and the NHS 14/01/15*

*Identifying a deprivation of liberty: a practical guide The Law Society 2015*

*Mental Capacity and Deprivation of Liberty; Law Commission's interim statement 2016*

## **Appendix 1 Procedure for Assessing Capacity**

a) Identify the area of decision making are there are concerns about:

For example there may be concerns about a person's ability to consent to (*their care plan/their mental health treatment / their physical health care or treatment / admission to hospital / sharing their medical information / where to be accommodated*)

*Example: can the person consent to mental health hospital admission?*

b) Identify what the person needs to know in order to be able to make this decision. There may be a need to find out more information about the person's situation in order to identify what the person needs to know. (the MCA refers to this as the potential consequences of deciding one way or another)

*Example: can the person consent to mental health hospital admission?*

What might the person need to know? : The person may need to know where the hospital is, what might happen when they are admitted, what might happen should they not be admitted. How being admitted or not may impact on their personal situation and well-being.

c) Identify who may be best to have the conversation with the person in order to make a judgement as to whether the person can understand and think through the information that is needed to make the decision. The Act refers to this as the 2 stage test; (see 14.3 above). The test is to check whether the person can demonstrate that it is more likely than not that they can understand and think through the pros and cons of the relevant information.

d) Whoever is undertaking the assessment needs to provide the information to the person about the concerns and what is being proposed using appropriate language or other communication methods suitable to the person, and then check the person's ability to understand and think through the information by asking open questions.

Example:

Give relevant information about the concerns:

*'There are concerns about .....you are not keeping well and /have not been eating enough/sleeping enough/out and about as you would normally be/taking the tablets that keep you well/your husband is struggling to keep both of you well/ your mood/ how distressed you have been.*

Give information about the options;

*The plan is .....to consider you spending some time in hospital at Wotton lawn hospital/ Charlton Lane Hospital for about 4 – 6 weeks / the doctors will check out your tablets / support you to get a programme in place to help with how you are feeling.*

Once the information has been given to the person, ask open questions to check the person's understanding and ability to think through the information:

*Can you tell me what this means to you?*

*What you think about this?*

*Can you say what it might mean to go to hospital? what might it mean to stay at home?*

In summary this is a 3 stage process:

- Check what information the person needs to make the decision
- Give the information to the person in the best way possible for them
- Check to see if they can understand the information and think it through

Example B: For people who have significant compromised cognition:

Example: Can the person consent to PEG feeding

It might be helpful to think through who is best to have this communication with the person and where possible use of someone who has a trusted relationship with the person, and who understands their communication style.

Give relevant information about the concerns:

This information would need to be given in an accessible form including objects of reference where possible. Introduce the topic: This may be in the form of symbols/photos/ drawings with simple basic language. This may be accompanied by signing or assistive communication devices.

For example: use smiley/sad/don't know face on a talking mat then offer a picture/draw a picture of the food/of being assisted/discomfort when swallowing/etc.

Give information about the options;

'PEG feeding is an operation/you need to come into hospital/there are risks of infection/it may not improve your chest.

Once the information has been given to the person, depending on how the person communicates, look to use non-verbal communication / symbols (total communication) for a response regarding the options.

Describe the person's response or take a photograph of symbols/cards to demonstrate your judgement on their ability to think through, weigh up and communicate their decision.

In summary this is a 3 stage process:

- Check what information the person needs to make the decision
- Give the information to the person in the best way possible for them
- Check to see if the person can understand the information and think it through

## Appendix 2

### Documenting Consent to Hospital Admission & Treatment

Figure 1: Assessment: Crisis Team/ Gatekeepers / Admitting Medic / Admitting Nurse

**Does the person have capacity to consent to mental health treatment in hospital?**

**Documentation:** Record the **outcome** of this capacity assessment in the 'Mental Capacity Assessment Form' within the MCA &BI folder on RiO

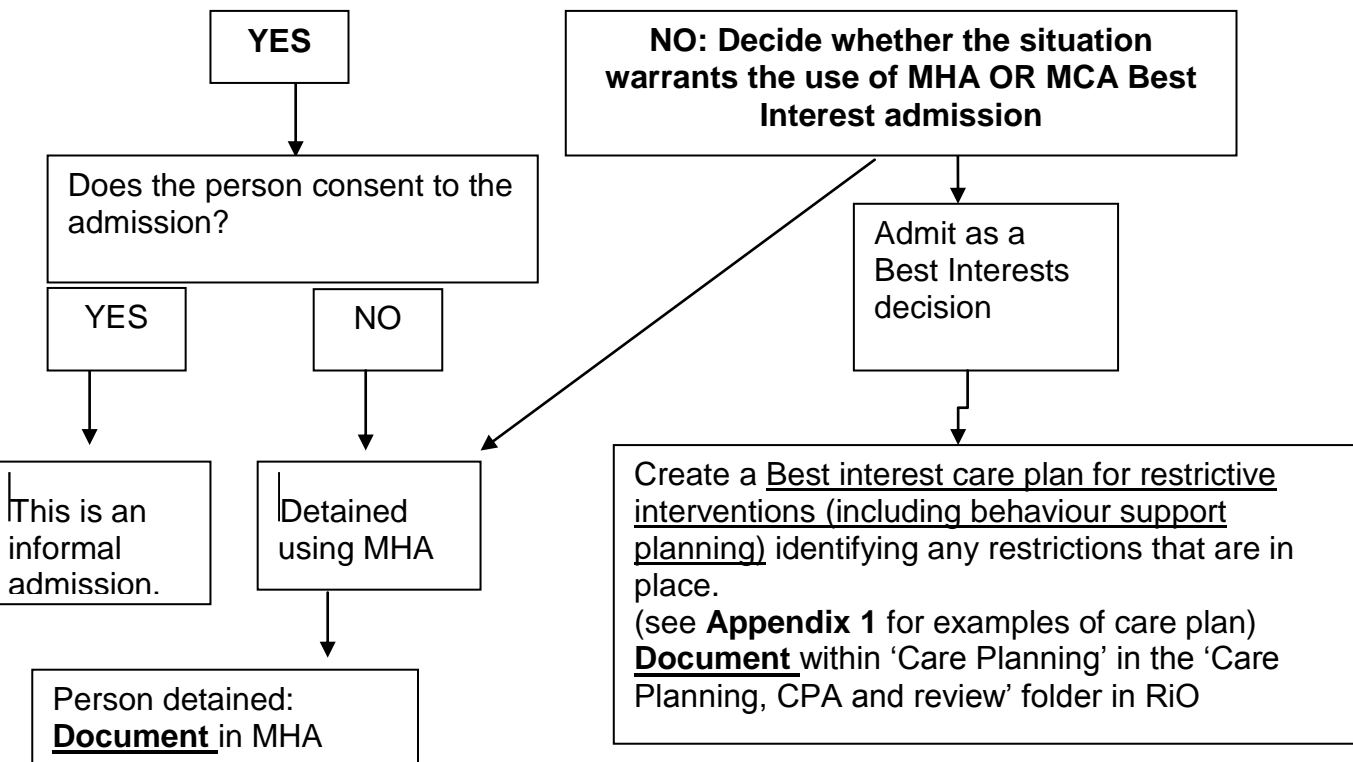


Figure 2: Review

**Check: Weekly discussion at MDT: Document in MDT progress notes**

Do the restrictions indicate a need for the MHA?  
(in other words 'does the patient need compulsory treatment in hospital?')  
(is the person objecting to mental health treatment)  
**If 'Yes' consider the use of the MHA**

If 'No' continue with Best interest care plan for restrictive interventions

NB: Do the restrictions being applied meet the Cheshire West Supreme Court threshold for deprivation of liberty?:

*le: Is the person under continuous supervision and control and not free to leave?*

**If 'Yes' make an urgent authorisation and DoLS application (Forms 1 and 4)**

### Appendix 3: Example Best interest care plan for restrictive interventions (including behaviour support planning)

<b>Environmental Restrictions</b>		
<b>Goals:</b>	<b>Activities:</b>	<b>Clients View:</b>
<p>For X to have the following environmental restrictions applied in order to promote safety/reduce harm to self/others: Environmental restraint: X is unable to leave ward due to key fob lock (X does not have access to the fob) Rationale: this is necessary due to risks relating to safety as X does not have road safety skills in traffic and risks becoming distressed / disorientated if she/he could leave the ward environment alone</p>	<p>ABC and RAG charts completed. <u>Primary prevention strategies:</u> X to have access and encouraged to go out into the garden area off the main lounge to the ward at least once a day X's husband to be encouraged to walk with X around the hospital grounds during his visits where the weather permits. <u>Secondary prevention strategies:</u> X to be diverted away from the main entrance to the ward using distraction techniques. Support X to walk freely up and down the main corridors of the ward where the ward situation allows <u>Tertiary strategies)</u> Planned PBM techniques to be used</p>	<p>X has a life history which indicates an active lifestyle and has always enjoyed walking. X is unable to express her/his wishes/preferences verbally and responds positively non verbally when on the move through a relaxed posture. Her/his non verbal response indicates frustration at times at not being able to walk through doors which she/he cannot open.</p>
<b>Physical Restrictions</b>		
<b>Goals:</b>	<b>Activities:</b>	<b>Clients View:</b>
<p>For X to have the following physical restrictions applied to maintain hygiene and dignity needs Physical restraint: holding X up to 6 times using planned techniques within 24 hour period so that essential care tasks relating to management of continence can be carried out. (refer to any associated PBM care plans) Rationale: this is necessary due to risks relating to breakdown of skin due to vulnerable skin integrity.</p>	<p>ABC and RAG charts completed. <u>Primary prevention strategies:</u> Provide drink (tea 2 sugars) prior to intervention to improve mood Put music on radio in the room whilst undertaking care tasks (prefers classical music channel) <u>Secondary prevention strategies:</u> One member of staff to talk with X using short sentences explaining what is happening whilst intervention being completed 2 staff to attempt intervention initially dis-engage for a period of 10 minutes if X becomes distressed and then return. <u>Tertiary strategies</u></p>	<p>X has a life history which indicates she was married for 40 years to X who describes her as a very private independent lady with regards to personal care. X expresses her view through non verbal behaviour which suggests she is frightened by struggling to remove herself from staff when staff carry out personal care tasks.</p>

	Increase to 3 staff using one staff member to distract and hold X's arms during intervention using PBM techniques if required .	
<b>Chemical Restrictions</b>		
<b>Goals:</b>	<b>Activities:</b>	<b>Clients View:</b>
For X to have the following chemical restrictions applied in order to improve well being and promote opportunities for positive social engagement : Chemical restraint: prescription of X medication to reduce agitation and distress administered x times a day. Rationale: this is necessary to reduce incidents of agitation and potential harm to X associated with times when she misidentifies other patients and the environment.	ABC and RAG charts completed. <u>Primary prevention strategies:</u> X to have opportunities to listen to music/be accompanied into a quiet area/walk around the corridor area of the ward/ engage with life history file <u>Secondary prevention strategies:</u> X to be diverted to a low stimulus area of the ward to walk with opportunities to talk with staff when required. X to be distracted with finger foods such as biscuits (prefers digestives) <u>Tertiary strategies)</u> Planned PBM techniques to be used	X has a life history which indicates a social lifestyle both at home and at work. She approaches others to engage and can misidentify people around her. This can cause her to react angrily when others respond to her with confusion.

Make a Progress Note Entry into the patient's health and social care record stating the following: Best interest care plan for restrictive interventions care plan completed.

NB: The restrictions being applied have been considered against the Cheshire West Supreme Court meaning of deprivation of liberty and it is judged that the person is not either currently under continuous supervision and control and/or is free to leave. The restrictions are necessary and proportionate to the risk of harm to X. This will be reviewed as part of the weekly MDT meeting.

Reference: DoH Guidance for providers : Deprivation of Liberty Safeguards (28<sup>th</sup> March 2014)

## Appendix 4: Best Interest Meeting Agenda

<b>BEST INTERESTS MEETING AGENDA</b>	
1.	<p><b>Introductions, purpose of the meeting and questions.</b></p> <ul style="list-style-type: none"> <li>• Housekeeping</li> <li>• Outline format of meeting – provide clarity that each person will have the opportunity to contribute</li> <li>• Information sharing and confidentiality</li> <li>• Statement of the legal framework</li> </ul>
	<p><b>Purpose of the Best Interest Meeting</b></p> <ul style="list-style-type: none"> <li>• Outline background facts</li> <li>• Clarification of decision/s required</li> <li>• Outline mental capacity assessment. If there is no capacity assessment specific to the best interests decision/s, THE MEETING MUST STOP.</li> </ul>
2.	<p><b>Gathering Information</b></p> <p><b>Views of:</b></p> <ul style="list-style-type: none"> <li>• The Relevant Person; <i>What is known about their present/ previous wishes, feelings, their values and beliefs (sustain this focus)?</i></li> <li>• Family members opinion</li> <li>• Professional opinion</li> <li>• IMCA (if involved)</li> </ul> <p>Decision-makers opinion</p> <p>Views from anyone named to be consulted, any LPA, EPA or Deputy of the Court of Protection</p>
<b>BREAK</b>	
3.	<p><b>Discussion of Viewpoints</b></p> <ul style="list-style-type: none"> <li>• Identify and be clear about the options</li> <li>• Discuss benefits and advantages of each option</li> <li>• Consider Best Interest Checklist</li> <li>• Balance sheet approach; <ul style="list-style-type: none"> <li>o Any medical aspects</li> <li>o Any welfare aspects (effect on lifestyle)</li> <li>o Any social aspects (effect on relationships)</li> <li>o Any emotional aspects (how they may feel or react)</li> </ul> </li> <li>• Assess likelihood of benefits/dis-benefits for each option</li> </ul>
4.	<p><b>Summary and Evaluation of Options</b></p> <ul style="list-style-type: none"> <li>• Summary of the information gathered and discussion (consider having this available visually)</li> <li>• Recommendations highlighting and dealing with any counterbalancing factors</li> </ul> <p>Decision of the meeting about the person's best interests</p>
5.	<p><b>Actions and Planning:</b> If the meeting cannot agree, decisions will need to be made about how to proceed e.g. 2<sup>nd</sup> opinion, involvement of an IMCA, mediation, Best Interests Case Conference, Court of Protection</p> <p><b>Communication Strategy</b></p> <p>Service User and Carer Involvement and Feedback</p>
<b>Any Other Business</b>	



## **Appendix 5: DoLS contacts for Gloucestershire & Herefordshire**

### **(Gloucestershire) Procedure for DoLS:**

If it is considered that the person is being deprived of their liberty and the person is not subject to the MHA, complete DoLS Form 1 which will give the ward an urgent authorisation lasting up to 7 days. (day of completion being the first day). At the same time as completing Form 1, Form 4 must be completed to apply for a standard authorisation. There is a combined form available which combines both form 1 & 4.

All relevant forms for DoLS applications can be found on the Trust intranet in essentials – policies – MCA & DoLS.

Applications to the DoLS Service should be made via the Adult Social Care Helpdesk by first notifying the Helpdesk in advance and then by e.mailing the completed Form 4 for Standard Applications for Authorisation together with Form 1 for Urgent Authorisations, or the combined form if applicable. [socialcare.enq@gloucestershire.gov.uk](mailto:socialcare.enq@gloucestershire.gov.uk)

The DoLS office is at Shire hall. The DoLS Specialist Practitioner can be contacted and can advise and direct to relevant forms and discuss cases etc.

Their number is: 01452 426005/ 01452 426192

### **(Herefordshire) Procedure for DoLS:**

Applications to the DoLS Service should be made via the Adult Social Care by first notifying the DoLS team in advance and then by faxing/ emailing or attending in person with the completed Form 4 for Standard Applications for Authorisation together with Form 1 for Urgent Authorisations, if applicable. A 'read receipt' should be attached to faxes.

Referrals:

Adult Social Care

(Opening hours: 08.45 - 17.00 Monday – Thursday 08.45 – 16.45 Friday)

Telephone: 01432 383645 Fax: 01432 260957

Email [DoLS@herefordshire.gov.uk](mailto:DoLS@herefordshire.gov.uk)

NB: emails must not contain any personal or confidential information unless encrypted. Please use Axcrypt software to encrypt confidential information.

The DoLS office is at Nelson Building, Whitecross Road, Hereford. HR4 0DG. They can be contacted on 01432 383654 and can advise and direct to relevant forms and discuss cases etc.

CQC MUST also be notified using their notification form once the result of the application is known. Once the form is completed by the practitioner, please insert the relevant codes and send to MHA administrator for processing.

Should a person die whilst being the subject of a Deprivation of Liberty Safeguards authorisation, the hospital must inform the coroner of this.

[http://www.mentalhealthlaw.co.uk/Deprivation\\_of\\_Liberty\\_Safeguards](http://www.mentalhealthlaw.co.uk/Deprivation_of_Liberty_Safeguards)

## DoLS Step by Step Process

1. Complete a care plan which identifies the restrictions in place and ways that the team are trying to minimise the restrictions; use the example 'restrictive interventions care plan' and personalise this.
2. Complete a capacity assessment in the MCA folder on Rio identifying that the person does not have capacity to make decisions to consent to being in hospital for mental health care and treatment. (If the person has capacity to consent to being in hospital DoLS will not be applicable)
3. If the opinion is that right now the DoLS is required complete the combined form 1 and 4. (if not right now but there is a time when it is expected to be required, just form 4 needs to be completed). **These forms are on the intranet: essentials – policies – MCA & DoLS.** (as soon as form 1 is completed this means the hospital has the legal authority to derive the person of their liberty for the next 7 days whilst waiting for the assessment process to happen)
4. Send the combined form 1 and 4 and capacity assessment form (print and scan), and care plan for restrictive interventions by e.mail to [socialcare.eng@gloucestershire.gov.uk](mailto:socialcare.eng@gloucestershire.gov.uk) and phone the adult helpdesk 01452 426868 to let them know it is coming.
5. Phone the DoLS team at shire hall on 01452 426005 or 01452 426192 to also let them know it is coming, and that it will need to take priority as the application is from a mental health hospital.
6. Complete the DoLS form for the person in their RiO records which is in the MCA folder on RiO
7. Upload the completed combined form to RiO documentation file and record in progress notes that DoLS has started as from date identified on urgent part of the combined form. Copy the forms and send to Debbie. Update the MDT records of the person's legal status.
8. Inform the person and the person's relatives of the DoLS. Also record you have done this on RiO. The person's relatives will need to know that they will be contacted and supported through the process by an advocate ( a DoLS IMCA). They also have the right to appeal the DoLS on the person's behalf. (This can be explained that; as a person is being kept in hospital the law requires that we must have safeguards for the person which includes the right of appeal)
9. Inform Debbie McCarthy (Mental Health Act Administrator) that the Urgent DOLS is in place with person's RiO number, name and ward.

10. The DoLS team at Shire Hall will now organise for a mental health assessor and a Best Interest assessor to come to the ward and do their assessments. When they have done so record in the person's progress notes that they have been to see the person.
11. Once 7 days has past which is the maximum period the urgent authorisation will allow for, if the assessments have not taken place the DoLS team may extend this for a further 7 days and will need to let you know. This will mean completing a further form which you can request that they send you.
12. Any conversations with the DoLS team at Shire Hall relating to the process needs to be recorded in the person's progress notes.
13. Once the assessments have taken place and the outcome is known /or the person gets discharged/or the person dies/or the person gets put onto MHA section - then let Debbie McCarthy know as she will complete the CQC notification form which must be completed. Debbie will also complete the relevant form for the DoLS Team at Shire Hall to let them know the outcome.
14. The DoLS team will send notice of the outcome of the assessment process. This will need to be scanned onto the person's records. Update the DoLS form in RiO according to the outcome.

NB: if the person dies whilst they are subject to a DoLS authorisation then the coroner needs to be informed as it considered a 'death in state'.

- The DoLS team at Shire Hall are known as the 'Supervisory Body' for the DoLS process
- 2gether Trust is known as the 'Managing Authority' for the DoLS process